WRMA
Walter R. McDonald & Associates, Inc.

FINDINGS FROM THE

SERVICE AREA 7 – SOUTHEAST COMMUNITY FORUMS

CONDUCTED FOR THE MENTAL HEALTH SERVICES ACT
PREVENTION AND EARLY INTERVENTION PLAN
IN LOS ANGELES COUNTY

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We greatly appreciate the assistance we received from the LACDMH PEI staff, the Service Area Advisory Committees, and the Community Forum Coordinators in coordinating the forums. We also extend special thanks to all the community forum participants for taking the time to engage in the community forums and for sharing with us their perspectives. The wealth of information provided during each of the breakout session discussions was invaluable to the formation of this report.

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I. OVERVIEW

The Los Angeles County Department of Mental Health (LACDMH) is engaged in an intensive, inclusive, and multi-faceted approach to developing the County's Prevention and Early Intervention (PEI) Plan to be funded through the Mental Health Services Act (MHSA) enacted by California voters in 2004.

The focus for developing the PEI Plan is at the Service Area level, utilizing informational meetings, key individual interviews, focus groups, and community forums in each of the eight geographic areas of Los Angeles County. Because each Service Area has distinct and varying populations, geography, and resources, it is critical for PEI services to be specific and responsive to regional and community-based needs.

PURPOSE. The community forums presented an exciting opportunity for community participants to make recommendations regarding priority populations and strategies for their communities that will help keep community members healthy.

This report presents the findings from the two Community Forums conducted in Service Area 7 – Southeast. The purpose of the Community Forums was:

1. To introduce participants to the Department of Mental Health's Prevention and Early Prevention planning efforts.
2. To summarize what was learned from existing research, other community residents and service providers in this service area about needs, barriers and strategies for providing quality prevention and early intervention mental health services, and
3. To hear suggestions for where and to whom Prevention and Early Intervention services should be provided.

OUTCOMES. The Community Forums had two specific outcomes:

1. To identify the specific priority populations to be served in this service area.
2. To develop recommendations for strategies to serve these priority populations.

II. COMMUNITY FORUM METHODOLOGY

The community forums were designed to provide community members an additional opportunity to provide their input regarding priorities and strategies for addressing the six MHSA priority populations. With one exception (i.e., Service Area 1), a total of two community forums were held in each service area, for a total of 15 service area community forums. In addition, one countywide forum was held that focused on specific populations. Each community forum was organized around age- and language-specific breakout sessions/groups for which community members registered in advance. Each service area community forum followed the same format and procedures.

PARTICIPANTS. Participants were community members interested in taking part in a discussion about the mental health service strategies that would most effectively address the mental health needs in their communities.

- Each Service Area Advisory Committee conducted a concerted outreach effort to educate the public about the MHSA and the PEI planning process. Outreach efforts also placed a large emphasis on encouraging community members to attend the community forums and provide their ideas and suggestions on effective ways to improve the social and emotional well-being of people in their communities.

- When interested community members registered to attend the community forum in their Service Area, they also elected to participate in one of the following five age-specific breakouts: 1) Children 0 to 5 years; 2) Children 6 to 15 years; 3) Transition-Age Youth, 16 to 25 years; 4) Adults 26 to 59 years; and, 5) Older Adults 60 years or older. Additional language-specific breakout sessions were conducted as needed. Each breakout session was comprised of no more than 35 participants.

- A total of 270 community members attended the two community forums held in Service Area 7 and represented a diverse array of community sectors. Of the 270 participants, 24 percent represented mental health providers, 20 percent represented consumers, 18 percent represented education, 17 percent represented social services, and 14 percent represented the underserved. Between 1 and 10 percent represented parents and families of consumers (10%), community family resource centers (9%), health (6%), law enforcement (3%), employment (1%), and the media (1%). Thirteen percent of participants did not indicate which sector they represented.

- A total of 13 age- and language-specific breakout sessions were held across the two community forums conducted in Service Area 7. A breakdown of the number of community participants in each breakout session/group by community forum is presented in Table 1.

Table 1.
Community Forum Attendance by Location and Breakout Group

Location	Children 0 to 5	Children 6 to 15	Transition-Age Youth 16-25	Adults 26-59	Older Adults 60+	Adults & Older Adults 26- 60+	Spanish*	Total
Norwalk	30	30	32	21	9		63	185
Bell Gardens	11		18			14	42	85
Total by Group	41	30	50	21	9	14	105	270

*Three Spanish-language breakout sessions/groups were held at the Norwalk forum location and two were held at the Bell Gardens forum location.

FORMAT. The community forums were organized and conducted in the same manner based on a three-hour or three-hour and fifteen minute time period. One of the two community forums in each Service Area was conducted on a weekday and the other on a Saturday, and took place either in the morning or in the late afternoon/early evening. Translators were available for mono-lingual speakers of various languages. The agenda at the forums included: 1) A welcome from the Service Area District Chief; 2) An introduction to the MHSA and prevention and early intervention Plan; 3) The results of the LACDMH needs assessment conducted in each area in terms of key indicators, key individual interview findings, and focus group findings; 4) Age- and language-specific breakout group discussions; 5) Key findings from breakout sessions/groups to all participants; and, 6) Final thoughts and acknowledgements from the District Chief and LACDMH staff.

BREAKOUT GROUPS. The age- and language-specific breakout sessions/groups were conducted by facilitators representing LACDMH as a neutral third-party. Each breakout session/group was conducted by a team of two staff members from Walter R. McDonald & Associates, Inc. (WRMA) and their subcontractors, EvalCorp Research & Consulting, Inc. and Laura Valles and Associates, LLC. One team member facilitated the breakout session/group, while another served as scribe and recorded participants' responses on flip charts, which participants could refer to throughout the discussion. The emphasis of the breakout groups was on identifying the top priority populations to be served in the service area and the appropriate strategies for the community.

III. SERVICE AREA 7 SUMMARY

Two community forums were held in Service Area 7 – Southeast. The first was held on November 18, 2008 from 9:00 am to 12:00 pm at the Marriot Hotel in Norwalk, and the second one was held on November 22, 2008 from 10:00 am to 1:00 pm at Bell Gardens High School in Bell Gardens.

A total of 13 age- and language-specific breakout sessions/groups were conducted in Service Area 7; of them, eight were age-specific and represented the five CDMH age categories. The age-specific breakout groups were distributed as follows in Service Area 7: two groups representing Children 0-5; one group representing Children 6-15; one group representing Transition-age Youth (TAY), 16-25; one group representing Adults, 26-59; one group representing Older Adults, 60 plus; and one group representing Adults and Older Adults combined. Five additional groups were Spanish-language. It is important to note that within each of the language-specific breakout groups, participants were asked to prioritize two of the five age categories, as well as to prioritize one priority population under each age category.

Table 2.
Summary of Breakout Groups' Priority Selections
Numbers in parentheses indicate the number of participants in the breakout group and the number of votes

AGE GROUP	PRIORITY POPULATION	PRIORITY STRATEGY
Children 0-5 Years		
November 18, 2008 Norwalk, CA (30)	1. Children/Youth in Stressed Families (20)	Embed service providers such as mental health specialists, family therapists, parent educators, "Mommy/daddy and Me" class facilitators, family literacy coaches and other mental health 'team' members at sites that at-risk families frequent such as preschools, early education centers, faith based organizations, and medical centers.
	2. Children/Youth at risk for School Failure (18 after tie-breaker)	Do not require 'medical necessity' designation to receive PEI services.
November 22, 2008 Bell Gardens, CA (Combined 0-5 and 6-15 age group) (11)	1. Children/Youth in Stressed Families (8)	Collaboration and unified approach between school, mental health providers, and social services to provide a broad range of services.
	2. Children/Youth at risk for School Failure (2)	Parenting classes for parents with children experiencing school failure.

AGE GROUP	PRIORITY POPULATION	PRIORITY STRATEGY
Children 6-15 Years		
November 18, 2008 Norwalk, CA (30)	1. Children/Youth in Stressed Families (10)	Provide school-based mental health services, including increased general and discretionary funds, training for teachers and administrators, counseling for children and their families, programs for pregnant teens, and collaborative services accessed via schools.
	2. Trauma Exposed (5)	Increase specific services and programs, such as domestic violence, rape, trauma, and victim assistance programs, and after school programs that have open eligibility requirements and allow for more sessions.
Transition Age Youth 16-25 Years		
November 18, 2008 Norwalk, CA (32)	1. Children/Youth at Risk for School Failure (10)	Increase school's capacity to meet comprehensive mental health needs by providing: 1) education, training and supports to the campus community (i.e., in-service to faculty staff and parents), and 2) direct services (i.e., counseling professionals, centers, programs with mentors/peer supports for youth and parents, etc.).
	2. Underserved Cultural Populations (6)	Meet basic survival needs including, employment, job development, small business development, increase food stamps, and travel vouchers to access mental health care.
November 22, 2008 Bell Gardens, CA (18)	1. Children/Youth at Risk for School Failure (7)	Provide outreach (in homes, peer to peer support groups, etc.); partnerships between schools and other agencies/sectors (faith based, planned parenthood, etc.); and after school/non-traditional programs
	2. Children/Youth in Stressed Families (6)	Provide additional training and education for school personnel utilizing youth to develop PEI strategies.
Adults 26-59 Years		
November 18, 2008 Norwalk, CA (21)	1. Underserved Cultural Populations (13)	Provide outreach through the media and peer to peer support groups.
	2. Trauma Exposed (8)	Provide prevention and early intervention services in existing community facilities.

AGE GROUP	PRIORITY POPULATION	PRIORITY STRATEGY
November 22, 2008 Bell Gardens, CA (Combined Adult/Older Adult) (14)	1. Individuals Experiencing Onset of Serious Psychiatric Illness (6)	Provide more services for special populations, such as immigrants, soldiers returning from Iraq, homeless, family members of the mentally ill, and recovery training for Latinos.
	2. Underserved Cultural Populations (5)	Increase education and awareness of mental health signs and services, including targeting older persons, training laypersons to do assessments, using schools and computer-based communications, and reducing stigma, discrimination, and barriers to accessing services.
Older Adults 60+ Years		
November 18, 2008 Norwalk, CA (9)	1. Underserved Cultural Populations (6)	Increase outreach to homebound/shut-ins.
	1. Trauma Exposed (5)	Increase outreach efforts utilizing the community health worker or "Promotora" model.
Spanish-Speaking Group		
November 18, 2008 Norwalk, CA Group #1 (8)	**Children-Ages 0-5(3)**	
	1. Children/Youth in Stressed Families (5)	Increase the availability and accessibility of culturally and linguistically appropriate mental health treatment, support services, and materials.
	TAY-Ages 16 to 25 (2)	
	2. Children/Youth at risk of School Failure (6)	Increase support to families to assist them in strengthening communication, rapport, and participation with their 16-25 children.
November 18, 2008 Norwalk, CA Group #2 (27)	**Children-Ages 6 -15 (12)**	
	1. Children/Youth in Stressed Families (15)	School-based mandated or incentivized teen parenting classes and support groups focused on effective parenting, child development, or mental health techniques.
	Adults-Ages 26-59 (9)	
	2. Underserved Cultural Populations (19)	Mandated or incentivized parenting classes focused on child development, dealing with difficult teens, and mental health education.
November 18, 2008 Norwalk, CA Group #3 (28)	**Children-Ages 6 -15 (21)**	
	1. Children/Youth in Stressed Families (20)	Low-cost and no-cost educational/capacity building opportunities for families available through Promotora-type programs, mobile vans, and outreach through community groups.

AGE GROUP	PRIORITY POPULATION	PRIORITY STRATEGY
	TAY-Ages 16-25 (21 after tie-break)	
	2. Underserved Cultural Populations (7)	Educational and motivational programs on mental health and self-esteem for parents and young people available through schools and counselors.
November 22, 2008 Bell Gardens, CA Group #1 (21)	**Children-Ages 6 -15 (10)**	
	1. Children/Youth at risk of or Experiencing Juvenile Justice Involvement (6)	No-cost, accessible, prevention education services for parents and teens such as parenting classes, early identification and screening, and service access advocacy.
	TAY-Ages 16-25 (8)	
	2. Underserved Cultural Populations (12)	Prevention education for parents and teens on mental illness, stigma, and tolerance towards the gay, lesbian, bisexual and transgender community and holistic psycho-education support groups, and teen mentoring programs.
November 22, 2008 Bell Gardens, CA Group #2 (21)	**Children-Ages 6 -15 (13)**	
	1. Children/Youth in Stressed Families (13)	Increase availability and access to no-cost, community-friendly services, including family therapy for undocumented families, which promote building healthy parent child relationships.
	TAY-Ages 16-25 (5)	
	2. Children/Youth at risk for School Failure (10)	DMH can use its influence to create safer spaces for marginalized groups and youth within the community, schools, and by mental health service providers.

IV. TOP PRIORITY POPULATIONS SELECTED

After the facilitator introduced all the participants to the goals and focus of the breakout session/group, each participant was asked to vote on one of the six MHSA-identified priority populations. Given the limited PEI resources, LACDMH requested the participants' assistance to identify which populations within a specific age group needs to be a priority for the provision of PEI services and supports. Table 3 shows the top two priority populations selected in each age category in Service Area 4.

In Table 3, each priority population selected by an age-specific breakout group is indicated by a check mark (✓). A denotation of "S" in the table indicates the priorities specified by the Spanish-language breakout sessions/groups.

Table 3. Top Two Priority Populations by Age Group

Priority Populations	Children, 0 to 5	Children, 6 to 15	Transition-Age Youth, 16 to 25	Adults, 26 to 59	Older Adults, 60+	Adults & Older Adults 26-60+
Underserved cultural populations			✓SS	✓S	✓	✓
Individuals experiencing onset of serious psychiatric illness						✓
Children and youth in stressed families	✓✓S	✓SSS	✓			
Trauma-exposed		✓		✓	✓	
Children at risk for school failure	✓✓		✓✓SS			
Children/youth at risk of or experiencing juvenile justice involvement		S				

The two sessions/groups representing Children 0 to 5 both selected Children and youth in stressed families and Children at risk for school failure. The one session/group representing Children 6 to 15 selected Children and youth in stressed families and Trauma-exposed individuals as their top priorities. Revealing slightly more variation in their selections, the two sessions/groups representing Transition-Age Youth (16-25) selected Underserved cultural populations, Children and youth in stressed families and Children at risk for school failure as their top priority populations. The single sessions/groups representing Adults (26-59) and Older Adults (60+) voted Underserved cultural populations and Trauma-exposed individuals as their top priority populations. Lastly, the session/group representing a combination of Adults (26-59) and Older Adults (60 plus) chose Underserved

cultural populations and Individuals experiencing the onset of serious psychiatric illness.

Participants attending the five Spanish-language sessions/groups identified the following priorities: Children 0 to 5 (Children and youth in stressed families); Children 6-15 (Children and youth in stressed families and Children and youth at risk of or experiencing juvenile justice involvement); Transition-Age Youth (Underserved cultural populations and Children at risk for school failure); and Adults 26-59 (Underserved cultural populations).

V. AGE GROUP RECOMMENDATIONS

The recommendations that emerged from the top priority populations selected in the breakout sessions/groups are presented below. Once each group had selected the top priority populations, they were asked to drill deeper and list the sub-populations that fell under each priority population.

Participants also were asked to identify strategies for addressing the mental health needs of the priority populations selected. At the end of the discussion, the strategies were consolidated and each participant was given an opportunity to vote for one strategy under each priority population. This section presents the top two to three strategies that emerged from those discussions as well as the sub-populations cited for each population by age group.

CHILDREN, 0-5 YEARS

PRIORITY POPULATIONS. Two age-specific breakout sessions/groups were conducted representing Children 0 to 5. In addition, Children 0 to 5 was selected as a priority age category in one of the Spanish-language breakout sessions/groups. These three groups representing Children 0 to 5 identified two priority populations. Table 4 shows the distribution of groups by priority population and the number of participants in the groups who voted for the top priority populations representing Children 0 to 5. In order to show the relative weight among the priority populations selected, the table includes the percentage of votes each priority population received in relation to the total number of participants across the groups representing each priority population.

Table 4. Percentage of Participants Who Selected the Top Priority Populations for Children, 0 to 5

Top Priority Populations Selected	# of Groups	# Votes Received	Total # of Participants	Percentage of Votes Received
Children and youth in stressed families	3	33	49	67%
Children at risk for school failure	2	20*	41	49%

*This priority population tied for second place with Underserved cultural populations in one of the sessions/groups. In a follow-up vote, participants selected it as the second priority population.

SUB-POPULATIONS. Table 5 displays how participants defined the sub-populations for Children and youth in stressed families and Children and youth at risk for school failure.

Table 5. Priority Population Sub-populations: Children, 0 to 5

Priority Populations	Sub-populations		
	Group 1 (N=30)	Group 2 (N=11)	Group S (N=8)
Children and Youth in Stressed Families	• Children raised by grandparents. • Children in foster care. • Children in families with multi-generational gang involvement; children in families that are low income, lack transportation, and live in over-crowded homes; children in families where one or more of the parents are suffering from a life threatening illness. • Children of non-English speaking parents with an elementary school or less education; or, children of immigrant parents. • Children in families where parents are suffering from mental health issues, suffering from substance abuse, have a family history of domestic violence, child abuse and/or lack parenting skills. • Children in single parent families; children in families with teen parents; children who are being raised by other children (e.g. siblings); children of homeless families; or, children where parents are incarcerated. • Families with children who have a pervasive developmental disorders. • Families that serve in the military.	• Children being raised by grandparents or other family members; children living in single parent homes; or, children of teen mothers. • Children of parents who have lost authority and are unable to discipline children appropriately. • Children experiencing difficulties in school. • Children with prior unsubstantiated child abuse reports and the child is still in the home with primary caregiver and was not removed from the home by Department of Children and Family Services; or, children at-risk of child abuse. • Children whose parents or caregivers are using or are addicted to drugs in the home and have co-occurring disorders; or, children who are "parentified," meaning that they have to act as a parent to themselves and/or siblings because their parents are not caring for them. • Children in isolated families, including immigrant families that are isolated from country of origin and other family members, may not have legal status in this county, and often lack resources,	• Children in the foster care system. • Children in homes where domestic violence is present; children of abused parents, inter-generational violence; children living with emotional or verbal abuse; or, children who have experienced physical or sexual abuse. • Children living in homes with alcoholic family members; or, parents with history of substance abuse or gang involvement. • Children living in homes where multiple families reside in one household; children left with other family members to raise. • Children of immigrant or undocumented parents; children of non-English speaking parents, children may not want to speak native language which may lead to problems when kids reach kindergarten. • Children of parents without traditional education who may not know how to access services. • Single-parent households. • Parents with undiagnosed mental illness. • Parents who lack communication or rapport with their children. • Families living in poverty; homeless

Table 5. Priority Population Sub-populations: Children, 0 to 5

Priority Populations	Sub-populations		
		especially financial; children of immigrant parents, where parenting approaches from their country of origin clash with those of the United States. • Children who have lost a family member because of death, parents migrated to another country without children, or separated due to deportation. • Families with children living in gang infested neighborhoods and at risk of being involved in gangs.	families; or, families where there is neglect and abandonment.
	Group 1 (N=30)		Group 2 (N=11)
Children and Youth at risk for School Failure	• All of the sub-populations identified for Children and youth in stressed families above. • Children entering kindergarten with no preschool experience or structured childcare, without exposure to pre-learning experience and/or skills; or, children who have been expelled from preschool and/or childcare facility. • Children with unidentified learning disabilities and/or developmental delays. • Children who lack love (attachment, support and/or a nurturing environment); or, children with low social/emotional capacity, self-regulation, etc. • Children exposed to violence. • Children with poor nutrition.		• Children who have poor school attendance; or, children who have failed in school repeatedly, such as being retained from advancing to the next grade. • Children with limited English proficiency (early immigrants). • Children/youth involved in gangs; or, children who have been abused. • Children who do not share feelings due to stigma. • Children with behavioral problems, such as attention deficit hyperactivity disorder (ADHD); children with learning disorders; or, children with developmental delays. • Homeless children. • Children who lack of role models; children of parents who do not know how to parent; children with parents/caregivers who use drugs and/or have co-occurring disorders; or, children of parents who are incarcerated. • Children of teen parents; or, children of divorced or separated parents.

STRATEGIES. The two to three top strategies selected by the three breakout sessions/groups representing Children 0 to 5 are presented in Table 6.

Table 6. Top Strategies by Priority Population: Children, 0 to 5

Priority Populations	Group	Strategy #1	Strategy #2	Strategy #3
Children and Youth in Stressed Families	1 (N=30)	Embed service providers such as mental health specialists, family therapists, parent educators, mommy/daddy and me class facilitators, family literacy coaches, and other mental health team members at sites that at-risk families frequent such as preschools, early education centers, faith based organizations, and medical providers (n=30).	N/A	N/A
	2 (N=11)	Utilization of a collaborative and unified approach among schools, mental health providers, and other social services to provide a broad range of services (n=6).	Family resource centers that include various services in one location (n=2).	Expansion of income/eligibility criteria in order for middle income families to access programs and services (n=2).
	S (N=8)	Increased availability and accessibility of culturally and linguistically appropriate mental health treatment, support services, and materials (n=5).	Increased awareness of and access to free or low fee parent support groups and educational classes (n=3).	N/A.
Children and Youth at risk for School Failure	1 (N=30)	Removal of 'medical necessity' designation required to receive PEI services (n=17).	Community-based networks to share resources, teach practices, and provide support and nurturing (e.g., the village model of child rearing) (n=9).	Creation of a transition pathway between pre-school, early childhood centers, day care, etc., and elementary schools (n=2).
	2 (N=11)	Parenting classes for parents with children experiencing school failure (n=3).	A social marketing campaign to reduce mental health stigma (n=3).	Mentoring programs created by positive community volunteers, including businesses, and school staff to expose youth to other environments such as art, theatre and nature (n=2). Additional strategy tied for 3rd place: Family service centers that offer a range of community resources and services (n=2).

CHILDREN, 6 TO 15 YEARS

PRIORITY POPULATIONS. One breakout session/group was conducted representing Children 6 to 15. In addition, Children 6 to 15 was selected as a priority age category in four of the five Spanish-language breakout groups. These five groups representing Children 6 to 15 identified three priority populations: Children and youth in stressed families, Trauma-exposed individuals, and Children and youth at risk of or experiencing juvenile justice involvement. Table 7 shows the distribution of groups by priority population and the number of participants in the groups who voted for the priority populations representing Children 6 to 15. In order to show the relative weight among the priority populations selected, the table includes the percentage of votes each priority population received in relation to the total number of participants across the groups electing the respective priority populations.

Table 7. Percentage of Participants Who Selected the Top Priority Populations for Children, 6 to 15

Top Priority Populations Selected	# of Groups	# Votes Received	Total # of Participants	Percentage of Votes Received
Children and youth in stressed families	4	58	106	55%
Trauma-exposed	1	13*	30	43%
Children and youth at risk of or experiencing juvenile justice involvement	1	6	21	29%

*This priority population tied for second place with Children at-risk for school failure and Children and youth at risk of juvenile justice involvement in one of the groups. In a follow-up vote, participants selected it as the second priority population.

SUB-POPULATIONS. Table 8 displays the sub-populations for Children and youth in stressed families, Trauma-exposed individuals, and Children and youth at risk of or experiencing juvenile justice involvement that were identified by the participants representing Children, 6 to 15.

Table 8. Priority Population Sub-populations: Children, 6 to 15

Priority Populations	Sub-populations			
	Group 1 (N=30)	Group S (N=27)	Group S (N=21)	Group S (N=28)
Children and Youth in Stressed Families	• Children of single mothers; or, pregnant teens; or, children with a lack of parental involvement or supervision. • Children in newly immigrated families that are isolated and lack awareness of mental health issues and services; families that lack awareness about risk factors and signs of mental illness. • Children with incarcerated parents or family members; or, children in families involved in gangs. • Children who are physically or sexually abused, and/or experience domestic violence; or, children in families that abuse substances. • Children with mentally retarded or mentally ill parents or family members. • Children in families with transportation challenges; • Children in families that are homeless or living with relatives; multiple families living in one dwelling; or, children living in hostile community environments. • Children and their families who lack the fundamentals of education; or, suppression due to laws being enforced that are not understood	• Children/youth exposed to violence from bullies. • Children/youth who are having sex early on. • Children/youth expelled from school. • Children/youth separated from their families by DCFS. • Children/youth with special needs (i.e. hearing disabilities). • Children/youth negatively influenced by peers. • Children/youth from single mothers. • Families and children living in domestic violence.	• Children/youth without goals or discipline; or, misunderstood children/youth. • Children/youth that continue the cycle of violence they witness at home. • Children/youth in gangs. • Children/youth who lack attention from their parents; or, lack support in their home. • Children/youth who are under the influence of drugs. • Children/youth who are exploring their sexuality.	• Children experiencing the first signs of mental illness with parents who do not understand/have difficulty accepting their mental health needs. • Children at-risk of school failure, especially those who do not speak English; children who are truant or absent from school; or, children at-risk of delinquency. • Children who have experienced trauma, have been abused, or live with other forms of violence. • Children with parents who are separated/ divorced. • Children using/abusing drugs, either to mask symptoms or who are self-medicating.

Table 8. Priority Population Sub-populations: Children, 6 to 15

Priority Populations	Sub-populations			
	by children and their families (such as curfews). • Children in families impacted by the economic downturn who may be accessing services for the first time; children in families on government support or welfare; or, children in families with multigenerational poverty, or those who lack resources. • Children and their families ineligible for services, even when insured; or, children and families who lack access to services due to city/geographic boundary lines and inconsistent programs. • Lack of schools' capacity to deal with stressed youth and/or their families.			
	Group 1 (N=30)			
Trauma-exposed	• Children experiencing extreme family violence; or children who are victims of verbal, physical, and/or sexual abuse. • Children in need of after care and support due to being traumatized by multiple violent incidents, or losing parents or family members as victims of violence and the grief and isolation can lead to a double trauma; or, children and their families or friends with untreated Post Traumatic Stress Disorder. • Children who witness violence in schools; or, children who observe violence, drugs, alcoholism, and homelessness in their community everyday (i.e., and become used to it/desensitized to it). • Children who experience bullying that leads to isolation; children unable to cope with peer pressure; or, children experiencing pressure to participate in activities such as choking, cutting, and inhalants. • Children living in sub-standard housing and/or living conditions; children who are interracial, or who live in tense, interracial communities; or, children that lack safe passages due to gang territories and/or gang-affiliated families. • Children with extremely ill parents and/or family members; or, children with substance abuse in the family; children with parents returning from the war. • Children with chronic illnesses; or, children with dietary or health issues such as obesity, diabetes, or malnutrition. • Children who are penalized in schools due to the over-interpretation of zero tolerance; children and their families subject to profiling and raids; or, police oppression and abuse. • Multigenerational families living in the same dwelling; or, new immigrants with assimilation difficulties.			

Table 8. Priority Population Sub-populations: Children, 6 to 15

Priority Populations	Sub-populations
	Group S (N=21)
Children at risk of or Experiencing Juvenile Justice Involvement	• Children living in domestic violence. • Children/youth who are using drugs. • Children/youth who are left without supervision for extended hours. • Children/youth who need acceptance from others (i.e., "followers"). • Children/youth exposed to trauma. • Children/youth in blended families. • Children/youth with sibling rivalry issues.

STRATEGIES. The two to three top strategies corresponding to the priority populations listed above and representing five breakout groups advocating for Children 6 to 15 are presented in Table 9.

Table 9. Top Strategies by Priority Population: Children, 6 to 15

Priority Populations	Group	Strategy #1	Strategy #2	Strategy #3
Children and Youth in Stressed Families	1 (N=30)	School-based mental health services that include increased general and discretionary funds, training for teachers and administration, counseling for children and their families, programs for pregnant teens, and collaborative services that are accessed via schools (n=21).	Increased access to services by opening up eligibility requirements, providing home-based services, and providing services where all communities can access them, including undocumented children and their families (n=4).	Interventions for children at-risk of gang or juvenile justice involvement, including children with incarcerated parents and with relocation services (n=4).
	S (N=27)	Teen parenting classes and support groups that focus on ways to raise children, child development, and mental health symptoms. Classes to be facilitated at schools. Parent participation to either be mandatory or by providing incentives (n=21).	Mandatory training for teachers on mental health/illness (n=2).	Wellness Centers for families without access criteria (n=2). <u>Additional strategy tied for 3rd place</u>: Screen and hire empathetic school personnel who love their profession and love to work with children with special needs (n=2).
	S (N=21)	Increased availability of and access to services and the promotion of building healthy parent child relationships. Free programming in community spaces and local mental health clinics, with the following: family therapy made available to undocumented families; more clearly and widely distributed information about existing services; and, the provision of incentives that get parents and children to interact more (n=12).	More presence and contact by DMH with schools in supportive relations with parents and their children (n=5).	Skill building workshop/classes for teachers, parents, and children with mental health needs (n=4).

Table 9. Top Strategies by Priority Population: Children, 6 to 15

Priority Populations	Group	Strategy #1	Strategy #2	Strategy #3
	S (N=28)	Low cost and no-cost education /capacity building opportunities for families made available through the Promotora-type programs, mobile vans, and outreach through community groups (n=12).	Early screening/evaluation completed for young children in school in order to identify any issues early on and provide appropriate counseling and other supportive services (n=7).	Increased culturally appropriate information/communication between DMH and schools, as well as television/media that will educate and support parents and reduce stigma (n=5).
Trauma-exposed	1 (N=30)	More specific services and programs, such as services for domestic violence, rape victims, victim assistance programs, services following traumas, and after school programs, that have more open eligibility requirements and allow for more sessions (n=17).	One-stop, multidisciplinary family centers and youth centers where children and their families can go to access multiple services (n=9).	A safe place for children to go to disclose abuse (n=1). Additional strategies that tied for 3rd place: Home-based prevention and early intervention services (n=1). Respite care (n=1).
Children and Youth at risk of or Experiencing Juvenile Justice Involvement	S (N=21)	Prevention education services for parents and teens such as, parenting classes on how to raise children, early identification on mental problems, and service access advocacy. Prevention services to be free, with no access criteria and with child care services (n=12).	Free individual counseling/therapy for children with no access criteria (n=5).	Training for school personnel on early identification of children with special needs (n=2).

TRANSITION-AGE YOUTH, 16 TO 25 YEARS

PRIORITY POPULATIONS. Two breakout groups were conducted representing Transition-Age Youth. In addition, four Spanish-language groups selected Transition-Age Youth as a priority age category. Each of the language-specific breakout groups selected one priority population within each age category (refer back to Table 2 for a visual representation of the breakout group priority population selections). Table 10 displays the distribution of breakout groups by priority population, as well as the number of participants in the groups who voted for the priority populations most important for Transition-Age Youth. In order to show the relative weight among the priority populations selected, the table includes the percentage of votes each priority population received in relation to the total number of participants across the groups selecting each priority population.

Table 10. Percentage of Participants Who Selected the Top Priority Populations for Transition-Age Youth, 16 to 25

Top Priority Populations Selected	# of Groups	# Votes Received	Total # of Participants	Percentage of Votes Received
Underserved cultural populations	3	38*	81	47%
Children at risk of school failure	4	33	79	42%
Children and youth in stressed families	1	6	18	33%

*This priority population tied for second place with children and youth at-risk of juvenile justice involvement. In a follow-up vote, participants selected it as the second priority population.

SUB-POPULATIONS. Table 11 displays the sub-populations for the five priority populations identified above by participants representing Transition-Age Youth.

Table 11. Priority Population Sub-populations: Transition-Age Youth, 16 to 25

Priority Populations	Sub-populations			
	Group 1 (N=32)		Group S (N=21)	Group S (N=28)
Underserved Cultural Populations	• Philippine immigrants; Southeast Asian Indian immigrants; Native American youth; isolated (i.e., culturally, geographically) Spanish speaking immigrants; isolated (culturally or geographically) Armenian speaking immigrants; isolated (culturally or geographically) Asian immigrants. • Uninsured Chinese immigrant single parents; or, uninsured college-aged youth because parents are uninsured or they have aged out of parent's coverage. • Detained Lesbian, Gay, Bisexual, Transgender or Questioning youth (mostly boys) in juvenile justice facilities; or, girls in juvenile justice facilities who are arrested and detained for prostitution. • Underserved and unemployed families of youth. • Youth experiencing physical abuse. • Youth whose parents do not support them seeking mental health services and remove them from those services. • Youth with divorced parents or absentee parent(s) due to incarceration or extensive work schedules.		• Single parents. • Undocumented students. • Individuals discriminated against due to their sexual orientation; or, individuals who are discriminated against due to their mental illness.	• Youth who do not realize they have mental health issues. • Youth who are first generation; or, youth experiencing acculturation. • Youth who are ignored by their parents or society at-large; or, youth who live in families where there is a lack of communication. • Gang-involved youth. • Homeless and unemployed youth. • Youth who drop-out of school, particularly those who are undocumented or lack resources; or, youth experiencing peer pressure.
	Group 1 (N=32)	Group 2 (N=18)	Group S (N=8)	Group S (N=21)
Children and Youth at risk for School Failure	• Youth with parents that are not actively involved in their education; or, college-aged youth who do not have financial or emotional support from home. • Armenian youth with parents who isolate their children due	• Teenagers in school; 9th and 10th graders (pre-16 year olds); teens involved in vandalism. • Teens dealing with substance abuse, gang involvement, and poverty; or, youth experiencing peer pressure	• Children living in high crime areas; children surrounded by negative environmental factors such as high rate of crime, drugs, graffiti or truancy. • Children of overprotective parents, parents in denial	• Youth with low grades who are not attending school. • Youth in gangs involved in violence and delinquency; youth who are incarcerated; or, Youth who are involved in prostitution. • Youth with low self-esteem;

Table 11. Priority Population Sub-populations: Transition-Age Youth, 16 to 25

Priority Populations	Sub-populations			
	to culture. • Youth with issues in the home that may impact their ability to do well in school such as, domestic violence and multi-generational gang and drug involvement within the family; youth with poor attendance in school due to emotional issues; or, youth who have not mastered academic basics yet are still promoted to next grade level where they are not academically prepared (i.e. social promotion). • Students with learning disabilities that do not have the ability to learn like the "other" students. • Youth who are involved in drugs, gangs or other risk taking activities. • Youth experiencing early onset of psychological disability. • Uninsured youth in families that do not know how to access or navigate community resources. • Female youth who are pregnant or have babies.	(truancy, gang violence, and drug abuse). • Youth/young adults struggling with sexual identity; youth with a lack of identity (loners). • Truant students; students who are bullied; or, Youth who are emotionally abused;. • Students who use the internet. • Students in special education; or, non-traditional students (artists, non-athletes). • Teen parents; or, youth without adult/parent support. • Youth with older siblings in gangs. • Young adults who lack opportunities to engage in constructive groups/activities; or, young adults who lack a social skill set.	who refuse to see when children are exhibiting high risk behaviors; or, parents who apply too much pressure, expect their children to be overachievers. • Youth who lack parental support; youth who lack communication with parents; or, youth who are latch-key due to parents working. • Youth from divorced families; or, youth seeking familial support, becoming involved with gangs. • Youth with access to adults who purchase alcohol on their behalf. • Youth with a history of physical, sexual or emotional abuse. • Youth with a record of graffiti; or, youth subjected by peer-pressure.	or, youth with high risk of suicide. • Youth with no focus or direction; or, working youth without goals for the future. • Youth seeking someone to confide in. • Youth who live in dysfunctional families or with divorced parents. • Youth who are apart from their family who is out of the country; or, youth who lack communication with their family. • Youth who are parents.

Table 11. Priority Population Sub-populations: Transition-Age Youth, 16 to 25

Priority Populations	Sub-populations
	Group 2 (N=18)
Children and Youth in Stressed Families	• Adult and single teen parents. • Persons in families dealing with substance abuse. • Persons raised in non-traditional families (e.g., raised by grandparents). • Persons who lack coping skills to deal with stressors; children who do not have an outlet to emotionally express themselves; or, young adults dealing with unemployment themselves or within their family. • Persons physically abused by their parents; or, young adults dealing with sexual abuse in their families. • Teens in poor families; or, teens in special education. • Victims of peer violence; youth witnessing violence (community and home). • Young adults who deal with language barriers; young adults dealing with physical disabilities/chronic illness; or, youth/young adults struggling with sexual identity.

STRATEGIES. The two to three top strategies corresponding to the priority populations listed above and representing groups advocating for Transition-Age Youth are presented in Table 12.

Table 12. Top Strategies by Priority Population: Transition-Age Youth, 16-25

Priority Populations	Group	Strategy #1	Strategy #2	Strategy #3
Underserved Cultural Populations	1 (N=32)	Meet basic survival needs, including employment, job development, small business development, food stamps, and travel voucher to access mental health care (n=9).	Increased mental health education workshops for youth and their parents that are ethnically and culturally-based, utilize existing cultural communication channels, (e.g., newspapers, radio, television, internet), and trusted community based settings (e.g., faith and/or community based organizations, schools, etc.) (n=5).	Mobile community outreach that allows for service delivery based on relationship building not on "diagnosis for eligibility" as criteria (because it is *prevention*, there is no "diagnosis") (n=3).
	S (N=21)	Prevention education for parents and teens in the following areas; education on mental illness, stigma, and tolerance towards the gay, lesbian, bisexual and transgender community. Other prevention services included; psycho-education from a holistic approach, support groups, and teen mentoring programs (n=13).	Provide free childcare for all prevention classes and programs mentioned above (n=6).	Not identified.
	S (N=28)	Educational and motivations programs on mental health and self-esteem for parents and young people available through schools and counselors (n=18).	Not identified.	Not identified.
Children and Youth at risk for School Failure	1 (N=32)	Increased school capacity to meet comprehensive mental health needs by providing: 1) education, training and supports to the campus community (i.e., in-service to faculty staff and parents), and 2) direct services (i.e., counseling professionals, centers, programs with mentors/peer supports for youth and parents, etc.) (n=7).	Targeted outreach and education to youth where they are located, outside of and away from high school settings (juvenile courts, internet and community colleges, etc.) (n=7).	Increased collaboration among schools, faith/community-based organizations, primary and mental health, and law enforcement to increase awareness regarding services and each other (n=6).

Table 12. Top Strategies by Priority Population: Transition-Age Youth, 16-25

Priority Populations	Group	Strategy #1	Strategy #2	Strategy #3
	2 (N=18)	More outreach in homes, peer-to-peer support groups, etc. (n=3).	More partnerships between schools and other agencies/sectors including faith-based organizations, Planned Parenthood, etc. (n=3).	More after school/non-traditional programs (n=3).
	S (N=8)	Increased support to families to assist them in strengthening communication, rapport and participation with their 16-25 children (n=8).	N/A	N/A
	S (N=21)	DMH can use its influence to create safer spaces for marginalized groups and youth within the community, schools, and by mental health service providers (n=9).	Programming that improves communication with students and serves to motivate them to stay in school (n=4).	Individualized and targeted counseling for parents and their children (n=4).
Children and Youth in Stressed Families	2 (N=18)	Additional training and education of school personnel, etc. (n=3).	Utilize youth to develop PEI strategies (n=3).	Increased outreach using current technology (n=2).

ADULTS, 26 TO 59 YEARS

PRIORITY POPULATIONS. One breakout group was conducted representing Adults. A second Adult breakout group was combined with an Older Adult breakout group and is reported on separately. Table 13 shows the number of participants who voted for the priority populations selected in relation to the total number of participants in the one Adults breakout group.

Table 13. Percentage of Participants Who Selected the Top Priority Populations for Adults, 26 to 59

Top Priority Populations Selected	# of Groups	# Votes Received	Total # of Participants	Percentage of Votes Received
Underserved cultural populations	1	13	21	62%
Trauma-exposed	1	8	21	38%

SUB-POPULATIONS. Table 14 displays the Adults sub-populations for the two priority populations identified above.

Table 14. Priority Population Sub-populations: Adults

Priority Populations	Sub-populations
	Group 1 (N=21)
Underserved Cultural Populations	• Hispanic community; Asian population; Spanish speaking (monolingual) adults; or, Native Americans. • Lesbian/Gay/Bisexual/Transgender. • Single parent families. • Veterans, uninsured. • Adults experiencing co-occurring disorders; or, adults that are developmentally disabled; Adults with HIV and/or AIDS. • Indigent populations; homeless and undocumented persons; or, low income persons that do not qualify for government services. • Adults dependent on public assistance.
	Group 1 (N=21)
Trauma-exposed	• Homeless; veterans; recent immigrants; or, single mothers who are head of their households. • Rape victims, battered women; or, domestic violence victims. • Families of persons dealing with substance abuse; or, people in recovery from substance abuse. • Adults who suffered from child abuse; or, persons exposed to continuing gang violence; victims of violence; or adults experiencing post-traumatic stress disorder. • Adults that have been in the foster care system. • Adults who have experienced multiple deaths or sickness in their family. • Victims of natural disaster.

STRATEGIES. The two to three top strategies corresponding to the priority populations listed above and representing one group advocating for Adults are presented in Table 15.

Table 15. Top Strategies by Priority Population: Adults, 26 to 59

Priority Populations	Group	Strategy #1	Strategy #2	Strategy #3
Underserved Cultural Populations	1 (N=21)	More outreach (use of the media, peer to peer support groups, etc.) (n=8).	More community education of mental health symptoms and wellness (n=7).	Integrated health and mental health services (n=2). Additional strategy tied for 3rd place: Increased collaboration among agencies and between the department of mental health and schools (n=2).
Trauma-Exposed	1 (N=21)	Prevention and early intervention services at existing community facilities (n=10).	Increased collaboration to provide services and support (n=5).	Increased awareness of trauma symptoms (n=4).

OLDER ADULTS, 60+ YEARS

PRIORITY POPULATIONS. One breakout group was conducted representing Older Adults. A second Older Adult breakout group was combined with an Adult breakout group and is reported on separately. Table 16 shows the number of participants who voted for the priority populations selected in relation to the total number of participants in the one Older Adults breakout group.

Table 16. Percentage of Participants Who Selected the Top Priority Populations for Older Adults, 60 Plus

Top Priority Populations Selected	# of Groups	# Votes Received	Total # of Participants	Percentage of Votes Received
Underserved cultural populations	1	6	9	67%
Trauma-exposed	1	5	9	56%

SUB-POPULATIONS. Table 17 displays the Older Adults sub-populations for the two priority populations identified above.

Table 17. Priority Population Sub-populations: Older Adults, 60 Plus

Priority Populations	Sub-populations
	Group 1 (N=9)
Underserved Cultural Populations	• Latino older adults (primarily Mexican): Spanish speaking; homebound, socially isolated, with physical and/or mental health issues; limited income; homeless veterans; those needing care giving/lack of services; those with cultural stigma/misinformation; and, those who lack of family support from adult children who have difficulty accepting needs of their older adult parents. • Asian/Pacific Islanders (similar characteristics as Latino older adults above). • Developmentally disabled older adults. • Homebound seniors.
	Group 1 (N=9)
Trauma-exposed	• Victims of civilian trauma versus military or war trauma; sexual abuse at convalescent homes; elder abuse by family members, specifically financial abuse; financial scams and other fraud, violence or criminal activities against older adults; or, victims of natural disasters such as fire, earthquakes, etc. • Older adults experiencing financial stress. • Older adults grieving loss (death) of spouse/partner, sibling, or other family member. • Older adults experiencing loss of independence; e.g., driving privileges. • Older adults contemplating suicide.

STRATEGIES. The two to three top strategies corresponding to the priority populations elected by the participants in the Older Adults breakout group are presented in Table 18

Table 18. Top Strategies by Priority Population: Older Adults, 60 Plus

Priority Populations	Group	Strategy #1	Strategy #2	Strategy #3
Underserved Cultural Populations	1 (N=9)	Targeted outreach to homebound and shut-in older adults (n=7).	Appropriate and accessible services (n=1).	Not identified.
Trauma-Exposed	1 (N=9)	Increased outreach efforts utilizing the community health worker or "Promotora" model (n=5).	Education on prevention of elder abuse (n=3).	Not identified.

ADULTS, 26-59 AND OLDER ADULTS, 60+ YEARS COMBINED

PRIORITY POPULATIONS. Priority Population Strategies and Sub-Populations: Adults, 26 to 59 and Older Adults, 60 Plus Combined. To manage the overflow of community forum participants who represented Adults and Older Adults, one combined breakout group was conducted. Table 19 shows the number of participants representing Adults and Older Adults who voted for the priority populations selected. The table also shows the relative weight between the two selected priority populations.

Table 19. Percentage of Participants Who Selected the Top Priority Populations for Adults and Older Adults Combined

Top Priority Populations Selected	# of Groups	# Votes Received	Total # of Participants	Percentage of Votes Received
Individuals experiencing the onset of serious psychiatric illness	1	6	14	43%
Underserved cultural populations	1	5	14	36%

SUB-POPULATIONS. Table 20 displays the priority population sub-populations identified by the Combined Adults and Older Adults breakout session.

Table 20. Priority Population Sub-populations: Adults and Older Adults Combined

Priority Populations	Sub-populations
	Group 1 (N=14)
Individuals Experiencing the Onset of Serious Psychiatric Illness	• Latinos/Hispanics; or, Asians. • Homeless; or, individuals losing homes and/or jobs due to economic crisis or natural disasters. • Gay/lesbian/bisexual/transgender individuals; incarcerated adults and older adults; or, new immigrants coping with culture shock. • Adults and older adults suffering from family loss; or, adults and older adults addicted to drugs or alcohol. • Adults and older adults with cognitive impairments or dementia; adults and older adults with mental health problems and lack of access to services; or, adults and older adults with physical illnesses that may contribute to mental illnesses. • Individuals facing stigma and discrimination from others for being different, and/or from within the mental health system. • Adults and older adults suffering neglect and/or abuse (such as domestic violence, assault, and verbal, physical, or sexual abuse); or, trauma exposed older adults. • Returning soldiers, particularly those who experienced trauma from war in Iraq; or, individuals facing barriers and discouragement from mental health workers when trying to seek employment.
	Group 1 (N=14)
Underserved Cultural Populations	• First generation immigrants. • Asian community; Russian, Romanian and Eastern European community; undocumented Latinos/Hispanics; Spanish speakers, or in some instances English speakers in Spanish communities; or, monolingual individuals lacking services available in their language. • Home-bound older adults; isolated older adults due to transportation, stigma, or social situations; socially ostracized adults/older adults; or, adults and older adults with transportation challenges. • Deaf, hard of hearing, and individuals who cannot speak; or, blind adults/older adults. • Developmentally delayed or disabled individuals; physically disabled adults/older adults. • Homeless, particularly homeless African Americans. • Older adults on fixed income, or social security; or, impoverished adults/older adults. • Adults/older adults with minimal education. • Religious organizations or affiliations.

STRATEGIES. The two to three top strategies corresponding to the priority populations elected by the participants in the Combined Adults and Older Adults breakout group are presented in Table 21.

Table 21. Top Strategies by Priority Population: Adults and Older Adults Combined

Priority Populations	Group	Strategy #1	Strategy #2	Strategy #3
Individuals Experiencing the Onset of Serious Psychiatric Illness	1 (N=14)	More services for special populations, such as immigrants, soldiers returning from Iraq, homeless, family members of the mentally ill, and recovery training for Latinos (n=5).	Education and training regarding mental health signs, issues, and services to the general public, faith-based organizations, and multi-disciplinary personnel using a peer model, public service announcements, and commercials (n=4).	Increased collaboration and training among mental health providers and other agencies, including Adult Protective Services (n=2). Additional Strategy Tied for 3rd Place: Provide relapse prevention strategies (n=2).
Underserved Cultural Populations	1 (N=14)	Education and awareness of mental health signs and services, including targeting older persons, training laypersons to do assessments, using schools and computer-based communications, and reducing stigma, discrimination, and barriers to accessing services (n=7).	Peer-to peer education and support services, including partnering with National Alliance on Mental Illness and hiring family members of consumers to work with particular cultural groups (n=3).	Services for specific populations, including increasing collaboration, interpretation services, and cultural sensitivity training (n=2).

VI. RECOMMENDATIONS FOR ADDITIONAL NEEDS OR POPULATIONS

At the end of the breakout session, participants were asked to identify any additional needs or populations that were not addressed during the discussion around priority population strategies. The suggestions offered are presented below by age and language groups.

ADDITIONAL NEEDS OR POPULATIONS	
Children (0 to 5)	• Increase Mommy and Me classes in Whittier. • Provide universal preschool or increase access to affordable preschools. • Provide all services to any family, no medical necessity required. • Address issues of multi-generational gang involvement. • Address issues of grandparents as care takers. • Provide bilingual, multicultural education for the preschool, not only English and Spanish. • Provide free or low cost day care and preschools for single parents. • Provide GED and parent classes for teen parents with childcare provided. • Provide regular mental health check-ups for the parents in order to protect the child or infant. • Place or link a mental health professional at all elementary schools. • Expand case management programs that already exist such as nurse/family partnerships, First 5 Welcome Baby, and Westside Infant Family Network (WIN) as these programs offer concrete, in-home parent education and resources. • Provide one-stop community locations for easy access to mental health resources (including in schools and community centers) where all services can be provided without the 'medical necessity' designation. • Provide mental health literature (available in English and Spanish) in every county hospital waiting room and give out regularly to community-based organizations and faith-based organizations. • Continue updating computerized county referral system. • Offer mental health counseling for law enforcement in schools and community for teens and adults. • Train police to be sensitive to the needs of the community and those with a mental health diagnosis. • Create services for working families with no insurance coverage.
Children (6 to 15)	• Address the needs of the following populations: o Co-occurring disorders in teens. o Substance abusers. o Sexually abused children who contract diseases. o Children with developmental and/or medical problems due to prenatal parental drug use. o Children and their families with insurance who are still unable to access or pay for services.
Transition Age Youth (16-25)	• Address the needs of Armenian youth. "They need special attention because they are a minority and are having terrible problems with Hispanic youth in the Montebello schools. Of course they are affected by drugs, and suicide and alienation but the added cultural and generational pressure is creating a severe strain on TAY."

ADDITIONAL NEEDS OR POPULATIONS	
	• Consider the following recommendation: "It is a very poor idea to influx a large amount of funding into large districts for SPA 7 (LAUSD) as they have only used funding for admin and it has NEVER been used to assist high school students in need. Using outside agencies with strong oversight of use of funds is much better. Must produce large number of students seen and change evaluators." • Adopt the following population related strategies: o Underserved Communities: Education and training in various existing social infrastructures (e.g., health clinics, churches, schools, media, etc.) to increase mental health service component and increase awareness to help screen, identify and refer for more intensive services. o Underserved cultural populations: Focusing on an approach of universal healthcare that would allow the TAY population to receive the treatment that they need with out having to worry about the expectation of another payment. The underserved population often skips treatment because it is not affordable, therefore worsening their conditions.
Adults (26-59)	• Provide transportation services to mental health services. • Build a culturally and linguistically competent workforce
Older Adults (60 Plus)	• Address the needs of the following populations: o Lesbian, gay, bisexual, transgender, questioning (LGBTQ) older adults. o Incarcerated older adults. • Require more training of In Home Supportive Services (IHSS) providers.
Adults and Older Adults Combined	• Encourage consumer organization networks.
Spanish Language Group	• Address the needs of the following populations: o Adults 26-59. o Marginalized cultural communities – people exposed to trauma. o Individuals experiencing the onset of psychiatric illness. o Children/Youth at risk of or already involved in the juvenile justice system. o People who are undocumented and need help so that we may improve their lives (children, youth, and adults) without concern about legal status. • Consider the following strategies for Children 0 to 5: o Address issues early as this is the time when the child's character is formed. Stop delegating our responsibilities to the schools and authorities. o Attend to marginalized groups and undocumented families. • Consider the following strategies for Children 6 to 15: o More training for teachers and school psychologists that teaches them to better identify a child with problems and be able to evaluate whether this is a mental health issue or a learning disability. o More community-based mental health clinics, especially clinics that can provide therapy for families even if they do have legal status in this country or do not have health insurance. o Youth groups where youth with feel comfortable, such as at community churches. o Offer support programs designed to educate youth about mental health and motivate

them to seek help.

- Consider the following strategies for Adults 26 to 59:
  - Provide workshops for those who have been trauma-exposed.
  - Offer more psychological help.
  - Make available clinics and help for people who do not have legal status in this country.
- Improve the quality and professionalism of school teachers.
- Utilize the media to educate parents and families about mental health needs and available services.
- More attention to schools to educate about mental health issues and support in general.
- Increase community awareness regarding abuse of elders, provide more supervision of their care-takers.
- Provide service and support for older adults who are isolated.
- Provide mental health services for older adults with early signs of mental health problems.
- Treat the elderly with respect.
- More emphasis on the needs of older adults.
- Educate community members on mental health and stigma.
- Support the Promotoras Comunitarias/Community Health workers.
- Provide counseling services to individuals with no prior criminal record who are arrested due to a mental health problem
- Offer individual counseling services with no access criteria or time limits.
- Use all forms of media to inform people about events such as the community forums.
- Use all means necessary to raise awareness of Latino community about the need to educate themselves about mental health issues.
- Inform community members on how programs and agencies function, what services are offered, and what recourse is available to consumer who have not been heard. “On paper a lot of agencies say they offer services, but in practice, this is not the case.”
- Provide parents who have faced trauma in their own childhood therapy or other programs so that they may become good parents.
- Help parents become responsible for the education of their children so that the children may mirror in school and in society the education and values they have learned at home from their parents.
- Build the capacity of parents to be responsible for the mental health of their children by offering mental health education through the schools.